

CITY OF WEST LAFAYETTE
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT PLAN ENROLLMENT FORM

The Internal Revenue Code (IRC Section 125) allows employees to have the following cost, if eligible, deducted from their paycheck before taxes are calculated on earnings:

- Dependent Child Care (IRC Section 129);

This is called a flexible spending account. In order for you to receive this benefit, you must complete this form, read the following terms and conditions and sign below. If you decide not to participate in this Plan, you must also complete your name and address and sign below in the appropriate space.

(Please Print)

Employee Name: _____ **Soc. Sec. No.** _____

Street: _____ **Date of Birth:** _____ **Sex:** M F

City/State/Zip: _____ **Home Phone:** _____

Single: _____ **Married:** _____ **Divorced:** _____ **Widowed:** _____

If a change in marital status has occurred, please provide date of change: _____

Spouse Name: _____ **Spouse Enrolled in a Flex Plan?** Y N

Employer: _____ **Not Employed:** _____

City: _____

Dependents:

First Name	MI	Last Name	Relationship	Sex	Date of Birth
_____	_____	_____	_____	M F	_____
_____	_____	_____	_____	M F	_____
_____	_____	_____	_____	M F	_____
_____	_____	_____	_____	M F	_____

- ☐ **Yes**, I elect to establish a flexible spending account and authorize a tax-free payroll deduction each pay period, as shown below. I understand that my total contribution to this account may not exceed the amount indicated for the calendar year. Indicate the amount of the payroll deduction you are hereby authorizing below.

Dependent Care Expenses - Maximum Deposit \$5,000/yr.* \$_____ x 24 pays = \$_____ per year
 (*\$2,500 for married but filing single tax returns)

My signature below indicates that I have read and understand both sides of this enrollment form, the descriptive material and all options available to me under the City of West Lafayette Flexible Spending Account Plan. I understand that my election may be changed during the year only because of an eligible change in my family status, and any unused balances in my flexible spending account will be forfeited. I authorize the City of West Lafayette to make the payroll deductions above for contributions to my flexible spending account.

Employee's Signature: _____ **Date:** _____

- ☐ **No**, I do not wish to establish a flexible spending account.

My signature below indicates that I have read and understand both sides of this enrollment form, the descriptive material and all options available to me under the City of West Lafayette Flexible Spending Account Plan. I understand that I am electing to NOT participate.

Employee's Signature: _____ **Date:** _____

Please read the important information on the back of this form!

I understand that:

- I cannot change or revoke any of my elections or this compensation reduction agreement at any time during the Plan Year (January 1st through December 31st) unless I have a change in family status (including marriage, divorce, death of a spouse or child, birth or adoption of a child, or termination of employment of a spouse).
- The Plan Administrator may reduce or cancel my compensation reduction agreement or otherwise modify this agreement in the event that it is advisable in order to satisfy certain provisions of the Internal Revenue Code.
- The reduction in my cash compensation under this agreement shall be in addition to any reductions under other agreements or benefit programs maintained by my employer.
- Prior to the first day of each Plan Year I will be offered the opportunity to change my benefit elections for the following Plan Year.
- This agreement may lower my contribution to Social Security and as a result my Social Security retirement or disability income may be reduced.
- This agreement is subject to the terms of the employer's flexible spending account plan, as amended from time to time, and shall be governed by and construed in accordance with applicable laws, and revokes any prior election and compensation reduction agreement relating to such plan.